UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
XOLAIR (Omalizumab)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA

- **DIAGNOSIS** moderate to severe persistent asthma.
- **DIAGNOSIS** allergic conjunctivitis and rhinitis, atopic dermatitis and food allergy.
- Age limit: ≥ 12 years old
- **Documented** severe persistent asthma of at least 1 year duration.
- **Documented** positive skin test reaction to a perennial aeroallergen.
- **Documentation showing** symptoms inadequately controlled with inhaled corticosteroids and beta-agonists.
- **Documented** forced expiratory volume in one second (FEV1) <70% predicted.
  Note: It is possible for one of these severe asthmatics to be better than 70% FEV1 on rescue therapy but they still struggle with optimum maintenance therapy. So in severe cases such as these we could consider approving Xolair.
- **Documented** pulmonologist or allergist consultation within the last 60 days.
- Body weight >30kg and <150kg.
- Baseline serum total IgE >30 and <700IU/ml.
- Patient prescription claim history must demonstrate routine use of inhaled corticosteroids for a 90 day period.

AUTHORIZATION:
6 months

RE-AUTHORIZATION:
1. Re-trial of corticosteroids and beta-agonists.
2. Re-application using criteria as outlined above.